Prevention and Harm Reduction: Opportunities for Collaboration to Address Opioid-Related Overdose

WEBINAR TRANSCRIPT

Date: Thursday, August 17, 2017

Facilitator: LaShonda Williamson Jennings, Associate Coordinator, SAMHSA's CAPT Southwest Resource Team

Presenters: Sharon Stancliff, M.D., Medical Director, Harm Reduction Coalition; Daniel Raymond, Deputy Director of Policy & Planning, Harm Reduction Coalition

---

[LaShonda Williamson Jennings]: Using the map, place your location. So, we'd like to know where are you calling in from today and then the other thing that we have -- if you would please answer the poll question and the question is on the left-hand side of your screen. It's "I have incorporated harm reduction approaches in my existing or former work. Never, a little, sometimes, often." Thank you, Sarah and Sharon. I see you all have placed yourself on the map. "A little." Very interesting. There are some folks who've answered "Often." Okay. So, the person who wrote "often," we can't see who you are, but throughout this webinar we'd love for you to chime in with some of the things -- the approaches that you've utilized within our prevention domain that are harm reduction strategies. Excellent.

Fantastic. It looks like we have people from all over the map, so folks from the East Coast, the Midwest, and we seem to be getting a little closer to the West Coast.

We continue to have doorbells. Welcome to the call. I'd ask you to please place yourself on the map. We'd love to know where you are calling in from today. And then we have a poll question. It's a brief one. It's "I have incorporated harm reduction approaches in my existing or former work. Never, a little, sometimes, or often."

So, some of the harm reduction approaches that I've used in the past were retail beverage server training, so I have provided some of those trainings and it was a harm reduction strategy.

Just to keep your minds going, what are some of those and start to think about, like, what are some of the strategies that you've utilized as you listen. You know, some of us may find out that we didn't know that we were utilizing some harm reduction strategies or even partnering with those harm reduction practitioners, but we will learn more in today's webinar. It's going to be a really good one and the group of folks who are facilitating this are

completely open to you putting any questions that you may have in the chat box. If there's a question that you have as we are going through this webinar please, please feel free to type it in the chat box on the left-hand side of your screen.

And, so we will get started in just a minute. For those who haven't answered the question in the left-bottom portion of your screen, please answer the question, "I've incorporated harm reduction approaches in my existing or former work."

For those just joining us, welcome to the call. I said this earlier to folks, so please take an opportunity to place yourself on the map. It's exciting seeing people place themselves on the map from all across the country. We've got the East Coast and the West Coast represented and where I am at: the great Midwest. Also, the South. So, welcome Peggy, our lone southerner here, in the Southwest rather.

We are going to get started in just a minute.

So, my clock says we have reached the top of the hour and we are going to get started. The presentation that you all have not only signed up for, but also agreed to participate in with us today is "Prevention and Harm Reduction: Collaborating to Address Opioid-Related Overdose." And so, the PowerPoint is going to come up in just a moment. It looks like quite a few of you all have had various experiences in utilizing harm reduction strategies and so we are about to hear more about what is harm reduction and where does that intersect with the work that we do as prevention providers? So, the folks who are going to present to us today, Sharon Stancliff and Daniel Raymond.

This training has been developed under the Substance Abuse and Mental Health Services Administration's Center for the Application of Prevention Technologies Task Order, so SAMHSA's CAPT. The views that are expressed in this webinar today don't necessarily represent the views, policies, or the position of SAMHSA or the Department of Health and Human Services. This webinar will be recorded and archived for participants to listen to later, as well as share with not only your subrecipients or your partners, but any sort of friends and family who may be interested in today's webinar.

I'm your facilitator. My name is LaShonda Williamson-Jennings. I have the pleasure of being the Associate Coordinator for the Southwest Resource Team for SAMHSA's CAPT.

So, in today's webinar, what we will be talking about is we will be defining harm reduction. What is harm reduction? We will also be discussing where prevention and harm reduction intersect. So, what are the things that we have common? What are common goals? We will also be discussing the benefits of collaboration to prevent opioid-related overdose and examples of successful partnerships. They've got a few great examples at the very end, so I'm telling you -- stick with us to the end. It will only get better.

Our presenters today are Sharon Stancliff. She is the Medical Director of Harm Reduction Coalition. And Daniel Raymond, the Deputy Director of Planning and Policy, Harm Reduction Coalition. We certainly appreciate you all participating today and sharing information.

So, let's frame the issue. Why are we talking about this today? You know, what, perhaps, interests you in this topic? We came up with about four things to frame this topic today for you. You know, prevention and harm reduction, we have some common goals. I think that we can first start at the very lofty one of -- we all certainly want a healthy community where people not only survive, but they certainly thrive in their communities. The other piece is that we want to reduce injury or death, you know, in hopes that a person who is an active substance user does get help.

Also, prevention incorporates some harm reduction strategies when addressing overdose and we will talk more about that today. Harm reduction strategies are outside the purview of substance abuse, substance misuse prevention, so, certainly we know that our prevention dollars -- that we have a scope of work. Just like anything else, we all have our task or our jobs that we need to take care of, so prevention, we have our discrete job and those who work as harm reduction practitioners have their job and what we are learning today is where do those jobs intersect, what are the things that we can do to really create a puzzle, a complete puzzle, so that we can get a sense of how to build this healthier sort of community that we envision in our minds. Also, collaboration is key for developing a comprehensive approach that can impact the opioid crisis. Certainly, it's something that we as preventionists have done well for many, many years and that is collaborate. What we are going to learn during today's webinar is how can we better collaborate? How can I better be a partner to those who are working in the harm reduction field?

So, here's a question. I want you all to join in quite early again. "What do you think of when you hear 'harm reduction'?" You'll see at the top of your screen there's a chat box. Begin to tell us what do you think of when you hear harm reduction? The first answer is "needle exchange." What else? What else are we thinking of when we hear harm reduction? So, "not allowed at our expense," so we cannot use our substance abuse prevention dollars for needle exchange. We see that there is not a lot that we can do. Other folks are saying we see "preventing death," "early education." That's good. And "naloxone, naloxone, naloxone." We've heard a lot about naloxone. Our surgeon general, our former surgeon general spoke a lot about naloxone and where it fits into our work. "Safe spaces to use." "Preventing death." You see someone wrote "minimizing risk." "Medication-assisted treatment." These are all great answers. "Safe environmental measures." "Sending to treatment instead of jail." So, this is someone who is looking at it -- how do we not keep filling our jail cells, but how do we get folks help? These are all absolutely great answers. I see "bupe" and I'm assuming that that's buprenorphine. So, great. Thank you so much.

Let's go back to our slides and you'll get an opportunity to hear from the folks that you came to hear from and that is Sharon and Daniel Raymond. I'd like to turn the time now over to Sharon.

[Sharon Stancliff]: Good afternoon, everyone. I think it's afternoon everywhere at this point. So, I'm Sharon Stancliff, the Medical Director of Harm Reduction Coalition and I just want to say I'm really excited to be on this webinar. It's a great thing to begin to pull together the pieces of prevention, treatment, and harm reduction because we all are working on the same issues.

So, I'm going to talk a little bit about what harm reduction is and kind of put it into the context of the history of harm reduction and, yes, needle exchange is one of the first things that came up and I will be focusing on syringe exchange, but also several other items.

So, we look at harm reduction as a set of very practical strategies such as some of those that you've already named, the syringe exchange, naloxone, treatment instead of jail, safer spaces for use -- a whole variety of things. But we are mainly aimed at reducing the negative consequences associated with drug use even when drug use continues, but we also include abstinence.

I think I'll be focusing more on some of the practical strategies that you all may be able to adopt into your work, but I also want to point out, it's a movement for social justice and it's built on belief in respect for the rights of people who are using drugs or used to use drugs or are affected by drug use in their communities. We have a whole set of principles on our website and I've pulled out a few to discuss in this session. They say it's practical strategies to reduce the harm when drugs are used. It also recognizes that drug use is common. There is really no society anywhere that has not had some means of feeling different or getting high, so we know that it's pervasive and might be great if it could stop, but we don't see that on the horizon. We do have a whole spectrum. I mean, when we talk about naloxone, that's taking somebody from the brink of death back to life, but we also support safer use. We support abstinence and if you were ever to come to a harm reduction conference you would actually find twelve-step meetings there for many of our leaders and participants to participate in.

Uses a low threshold entry requirements and I haven't thought of a better word for low threshold, so let me explain it a little bit. This means that there is not a lengthy process to be able to come to a syringe exchange and exchange a dirty syringe for a clean one. There may be a short registration process, but things are very simple. We try to place our services where people are found, including doing outreach on the street, putting the facilities in neighborhoods where people are, and simply requiring that somebody show up and they may just show up and get a syringe one day. They may come back and just sit down and get a little bit of peace and quiet the next day and maybe the next day they will start participating in groups or in maintenance of our facilities. Sometimes you just see somebody

pick up a broom because they see, "oh, it could be tidier here." So, people can enter at whatever level they want.

Then, finally, and I think I can show you this through the history, it ensures that people that are using or used to use drugs have a real voice in the creation of programs and policies. Essentially, it's people who use drugs that have created harm reduction and we always need to ensure that their voices are heard loud and clear as things change.

So, let's go back in time for a minute or two. The first-- harm reduction really prevents everything. I'm a family medicine doctor and that's what I have done with most of my work. I don't get to cure very many diseases, but I can prevent the harm that diabetes does. I can prevent the harm that HIV does. And it's the same with harm reduction. We can prevent a problem from creating other problems.

So, the first exchange was actually back in Amsterdam. It predated HIV by just a couple of years and it was initiated by a group called The Junkies Union. They named themselves that as a group of users that were finding pharmacies were a little reluctant to sell syringes and they were aware of hepatitis B, so they started their own syringe exchange which was rapidly taken up by the Amsterdam Department of Health. Then it became apparent that HIV was spreading rapidly among people who injected drugs, and I think one of the first exchanges in response to that was in England, in Merseyside. They developed the syringe exchange in response to HIV, and what we've seen over the years is the places that developed needle exchange very early in the years of the HIV epidemic didn't end up having an epidemic among injection drug users. Unfortunately, that was not the case in the United States. It was harder to get it going here.

This is a picture of Dave Purchase who started the first publicly-funded syringe exchange program in Tacoma, Washington. Most appropriately named after its geographical location, Point Defiance. And slowly these developed across the country, sometimes out of peer initiatives. In New York City, it was started out of ACT UP to prevent HIV transmission and to save lives. And, as I think people noted earlier, the syringe exchange is sort of the hallmark of harm reduction, but we have moved onto other interventions and activities.

So, I mentioned the places that started syringe exchange early, Australia, many parts of Europe, didn't see HIV much among their injectors. We were later in the United States, but I think this is a pretty amazing graph of what happened in New York City. This is comparing the number of annual syringes exchanged each year, that's the blue line and the numbers are on the left, compared to the annual incidents per 100 person-years, each year, over that course of time. In 1990, there was an underground syringe exchange going on -- not a lot of syringes going out, and by the time we got to about 2000, there were about 3 million syringes exchanged each year. Corresponding to that was a decrease in annual HIV incidence among injectors going down from about 4 per 100 person-years to less than 1.

And, to put it in another way, in 1990 about 50% of the people that were injecting drugs had HIV. At this point, it's somewhere around 10%, and we need to remember that the people that inject drugs are also at sexual risk, just like much of the population. So, this has been a stunning change in New York and we are seeing it in some other parts of the world as well. So that's a little background on syringe exchange and I know that that's not something that you can use your dollars for, but what I'd like you to take away from that is the fact that it was an intervention that was created by the people in need. Now, the naloxone, or Narcan, I think is fairly central to many of the activities at this point as we are losing, perhaps, as many as 50,000 people to opioid overdoses each year at this point.

So, what is naloxone or what is commonly known as Narcan? Naloxone is a medicine that completely blocks the effects of opioids. So, if somebody is in pain, it will bring back the pain. If they are intoxicated or high, they will suddenly become normal and if they are stopping breathing because of an opioid, which is how opioids kill, they will start breathing again. It essentially goes in and pushes the opioids off the body's opioid receptors and blocks them for 30 to 90 minutes and if you are not familiar with receptors think about it as a lock and key. If you have ever gotten -- put the wrong key into a lock, you can't open the door and you can't get the key out. It's blocked it so you can't get the other key in, so naloxone blocks the keyholes for the opioids and it lasts 30 to 90 minutes, which in most, the majority of cases, is enough time for the body to metabolize the heroin or the Fentanyl or whatever opioid is causing the overdose and they should be fine. That being said, we always want to send people off to the emergency department in the case of an overdose.

So, again, a little history of naloxone access. Italy recognized this as a problem fairly early on and made it over-the-counter for people that were injecting opioids to be able to purchase. It came to this country and I think that Dan Bigg who ran the Chicago Recovery Alliance started distributing naloxone back in 1996 and I think he was brilliant and he should be -- he is very much recognized for that. They ramped up their distribution of naloxone to people that used drugs in about in the year 2000. There was the first Opioid Overdose Conference back in 2000, Preventing Heroin Overdose, Pragmatic Approaches. The first legislation allowing for naloxone to be used by nonmedical people passed in New Mexico in 2004, followed by Connecticut, and then in 2006, New York state.

So, I'm going to show you another map in a little while. This is what naloxone laws looked like in 2006. We had three states that had made laws regarding naloxone and then we had several really leading cities that were providing naloxone at that time. New York City, San Francisco, and Chicago. Keep this map in your mind when we move ahead.

So, I showed you that syringe exchange is associated with major reductions in HIV transmission. I also want to show you that naloxone is associated with reductions in overdose death. So, Massachusetts has launched major naloxone initiatives across the state and when they had gotten to about 3000 kits distributed in several different cities, they sort of took a snapshot. They found that 327 people had reported using their kits and 87%

of those, by the way, were drug users. No one in the study -- no one that was reported -- died. And what they found is that they gave a little bit of naloxone 1 to 100 per 100,000 people in the city, their reduction was 27% and if they gave it to more than 100 per 100,000, nearly a 50% reduction in overdoses.

Here are a couple of -- here are a few of the folks that have been really high profile that died. And I want to turn it over to LaShonda for a little poll.

[LaShonda Williamson Jennings]: Thank you so much. So, you all, on your screen, at the top portion of your screen, there's a poll question, "What impact has the death of public figures had on your own work in opioid overdose prevention?" So, what impact has the death of public figures had on your own work in opioid overdose prevention? The death as you see in 2008, Heath Ledger passed away. In 2012, Philip Seymour Hoffman. And then in 2016, most recently from a Fentanyl overdose, Prince. So, I'm seeing none, none, none. Sharon, tell me what -- in your work, you know, what have these overdoses, these high-profile overdoses, what impact does it have on harm reduction?

[Sharon Stancliff]: Well, for us, we spent our first years under a grant from the New York State Department of Health calling places, begging, let us come and teach you about naloxone. Let us come and help your agency distribute free naloxone and we were banging on the doors, and so we would go anywhere at any time. We'd, you know, bicycle anywhere across the state to get -- not really bicycle, but we would do whatever we could to convince programs to start and I think really it was Philip Seymour Hoffman's death that brought about a change at least in New York. Perhaps because it happened in New York.

Suddenly, we felt like our phones were really ringing off the hooks and suddenly we had to say, okay, you come to us. We are going to hold big sessions for you to learn about this because we can't go everywhere anymore. So, I think that brought it home to many people and then Prince, we were really -- we were kind of rolling at that point, but it was -- I mean, that -- all of them had been tragic and the tragedy of Prince really sort of brought home to us what was going on with Fentanyl being available. His may have been pharmaceutical. I don't think so, but we now have a lot of Fentanyl mixed into the heroin which has made the supply even more unpredictable and, unfortunately, we are going to see trends in overdose deaths going down, but they are continuing to go up.

[LaShonda Williamson Jennings]: Thank you. Thank you. We are seeing the folks in the chat box have placed lots of -- it sparked people to talk about overdose. It brought some more attention, so it's created this chatter about overdose and I think that what gets at the heart of this is what some person wrote which is it humanizes opioid overdose deaths. So, it's so interesting that what would humanize opioid overdose deaths are not the people in their community dying, but these high-profile figures, so, you know, thank you whoever wrote that but I think that there is some truth in that. It familiarizes people more quickly with

the rationale for the need to do the work. It has changed the perception of the population that are at risk for some of my clients.
[Sharon Stancliff]: Right. And I also see the comment that it's quite different than the days of the cocaine epidemic when things were criminalized and that has been a big difference with the opioid overdose crisis that we are having, and it is somewhat of a different population and it sometimes does feel unfair so I really want to point that out and thank you for writing that, whoever did as well.

[LaShonda Williamson Jennings]: Yeah, absolutely. Well, thank you all for participating in this chat poll and we will go back to our slide deck.

[Sharon Stancliff]: Thanks, LaShonda. And, remember that map I showed you with three states that has passed laws? This here marked the final couple of states that have passed laws allowing nonmedical people to carry and use naloxone if they in good faith believe that they're seeing an overdose. So, it's become a lot easier, and I hope, you know, I hope some of the seminar and some of the work we do helps you all in your work being able to get the word out about naloxone and help people get access to it -- and I'll talk more about that in the example section.

So, just to recap a little bit, I hope I've demonstrated to you that some of our strategies in harm reduction are truly evidence-based in the same way we are looking at evidence-based treatment for people that have opioid and other substance use disorders, and that it's really been shown to reduce both morbidity, deaths from overdoses, deaths from HIV and AIDS and mortal -- I'm sorry. I got my morbidity and mortality -- mortality from overdose and HIV-AIDS, and reduces the morbidity, the illnesses from HIV, from hepatitis C, from the various other infections that people get when they are injecting.

Naloxone distribution as opposed to syringe access has been fascinating. It really originated in the tradition of harm reduction, but as I'll talk about a little bit more later, it's been picked up widely across disciplines. We started with syringe exchanges. Drug treatment programs began to realize that when they discharge people from treatment, unless they are on methadone or buprenorphine, they are at risk of overdose, so they, at least for us in New York, were the second group to take it up. Then law enforcement began to realize they were the first ones on the scene at many overdoses and they wanted to carry naloxone. And I'll talk more about correctional facilities. Schools have picked it up. Naloxone has proven to be really effective in so many different arenas at this point. It's been fascinating to see.

Finally, we will get to more sharing best practices through collaborations, but it truly is a key to the success in reducing overdose deaths. When I first came to Harm Reduction Coalition, I did not expect to be working closely with law enforcement and with corrections or, even though I came from drug treatment, that closely with drug treatment, but we have been forced to make those collaborations, and we found many, many things in common including

our goals, but also friendships have developed across those collaborations, so I hope that this can help move that along. I think we maybe another poll at this point.
[Daniel Raymond]: Great. Thank you, Sharon. Hi everyone. This is Daniel Raymond from Harm Reduction Coalition and now that Sharon has given us an overview and a brief history of harm reduction, I wanted to drill down a little bit more to talk about ways that harm reduction and prevention can actually intersect and overlap.

So, I'm going to start with a slide of an image that most of you are probably familiar with. This is the IOM, or Institute of Medicine Model for Behavioral Health, or also known as the Continuum of Care, and you will see it starts with promotion on the wedge at the far-left side moving into prevention, treatment, recovery, maintenance. As we go forward we can look at the spheres for prevention. So, we talk about prevention in terms of universal prevention, targeting the general population regardless of specific levels of risk. We talk about selective prevention -- that's where we focus on particular subgroups that may be at higher risk using targeted strategies, and then indicative prevention, so people who have initiated substance use or other high-risk behaviors, they haven't developed -- so prior to the onset of a substance use disorder per se, but they are clearly are at risk of moving in that direction and that's what we are trying to prevent. So, for example, people who might be flagged if you are doing SBIRT (screening, brief intervention, referral to treatment).

And so, when we think about where people are on the spectrum of use we can see that people in the selective and indicated areas, particularly, are maybe starting to use or misuse substances and, of course, as we move to the side on the right, that we have case identification for people who are not currently in treatment, who may not have been diagnosed with a substance use disorder, moving into treatment, long-term treatment, and maintenance. So these middle areas really are the areas where harm reduction works, that harm reduction is engaged at an individual level, at a structural level with people who have initiated some kind of use, and we think about ways to prevent that from progressing to more hazardous patterns and also even as people move into the treatment and recovery phase that may apply to -- if people are using multiple substances, that may apply to one of their substances, but they may still be at risk of harm and benefit from harm reduction if their use of other substances continues.

And I wanted to turn it back to LaShonda quickly, because I think we are interested in doing another poll question to hear from people on this call.

[LaShonda Williamson Jennings]: We do have a quick poll. Thank you so much, Daniel. "Are you or your subrecipients addressing populations that are misusing substances? No, we are not; no, but we are considering it; we have partners who are doing that work; and then yes, we are." It looks like most folks are saying "yes, we are. Yes, we are, or our subrecipients are addressing populations that are misusing substances."

And you all -- as you answer these questions, if you've already written down some questions on a piece of paper in front of you or if you are formulating a question in your mind, please, please, feel free to write that question down in the chat box. So, we are here and ready and interested in hearing from you and hearing your questions for Sharon and Daniel.

So, thank you all so much. It looks like we are kind of coming to a close here with this. It appears that most people are or their subrecipients are addressing populations that are misusing substances, so we are talking about that selective and indicated section of the work. So, great. Let's move on.

[Daniel Raymond]: Thank you, LaShonda. And so, this is really the sweet spot when we are talking about the intersection of harm reduction and prevention. So, to build on what Sharon was talking about, I want to start by identifying some common shared goals. That harm reduction and substance use, substance misuse prevention, we are both really contributing towards some of the same areas in reducing the adverse health and social consequences of substance use, providing multiple points of intervention across the spectrum of substance use, and developing coordinated strategies that operate in tandem, at both the individual and community levels. I see a chat comment about some resources requested around considering implementing a drug prevention program or needle exchange program, and we'd be happy to circle back to that -- and we certainly have a lot of resources on our website. We will put up the slide for that. It's www.harmreduction.org for people specifically interested in developing a needle exchange program.

Now, common threads. We spoke just a moment ago about common goals, but I think that there are some shared principles or shared values. As Sharon noted, both the prevention field and the harm reduction field are very attuned to emphasizing evidence-based interventions. We don't want to just try something that feels right. We don't want to just go with your gut instincts on what we should be doing. We want to test out these models, get the research, get the data, and then take what works and move it forward and scale it up. I think that we also have common cause in recognizing the harmful impact of stigma and stigmatizing language, and that's been a big discussion across the overall substance use field over the last few years and I want to specifically acknowledge the leadership on that issue of our former "drug czar," the head of the Office of National Drug Control Policy throughout 2016, Michael Botticelli, on leading a lot of that discussion.

Like, prevention, harm reduction is also focused on not just the risk factors, but also the protective factors. Those factors that foster resilience, that foster things like social capital, and so we talk about that in some cases as taking a strengths-based perspective on our work.

I know that the prevention field has been very attentive to the role of adverse childhood experiences. We know that those are often very predictive of risk for that prevention

continuum that we talked about and that often manifests in the people that harm reduction programs are seeing and engaging with, which has led us all to be more thoughtful about incorporating trauma-informed approaches.

We certainly have a common thread in the importance of cultural competency and our ability to work with and engage and make meaningful impact with a whole range of diverse populations. Socioeconomic, racial and ethnic, sexual orientation, and so forth. That's definitely a common thread that I think unites prevention and harm reduction and gives us an opportunity to find some common language. Finally, we are not just working with people on an individual basis that, ultimately, we understand that the full impact of our efforts won't be felt unless we are also working at the community level and taking approaches that address different risk environments.

Now, we do also continue to do that individual level work, however. So, for the prevention side, especially for universal prevention, we are focused on individual people, often youth, at risk of substance use initiation. I think the classic perspective of who harm reduction works with are people already using substances and are at risk of adverse consequences. So, whether that's developing a substance use disorder, overdose as Sharon talked about, some of the other health and social consequences. Now, from our perspective, prevention and harm reduction, as well as treatment and recovery, are addressing the same person at different stages and these stages can be fluid. People can move back and forth across these different stages. So, it behooves all of us to be able to essentially link arms and think about how our work might overlap, how our work might be mutually reinforcing, and support each other's efforts.

Now, that requires us to break down some of these binaries and I'm thinking specifically here that substance use patterns are not all or nothing. That it's not so much a light switch that you can turn on or off. That we often see, especially early on in that continuum, some intermittent or experimental or recreational use that may start to shade into routine or potentially harmful use. The example of binge drinking comes to mind. We also see other opportunities for early intervention and indicative prevention. I mentioned SBIRT earlier and different layers of prevention, so some of the things that we sometimes talk about in harm reduction world is preventing secondary initiation of additional and potentially more harmful drugs even for somebody who might have an established drug use pattern, or preventing transition to riskier forms of use. So, somebody might be using drugs but if we can think about how to intervene before they begin injecting drugs, then we've prevented a more harmful pattern of substance use. So, when I talk about breaking down boundaries, thinking about this more as a spectrum, that fluidity that people may be moving back and forth so that there are different levels that we can intervene on.

Now, zooming out beyond the individual level, we also recognize the importance of family and peer group influences. And, in particular, from a prevention point of view, substance use initiation is typically a social process that occurs in the context of relationships with a

current user. So, if I've never used drugs before, then it's probably more likely that the first time I use drugs is with somebody, maybe a more experienced or older user, rather than just on my own by myself. So, social norms, family and peer influences, and exposure to people around you who might be using substances or alcohol can be a very important factor to consider from a prevention point of view. That's another area of overlap or intersection is that those people in that family or peer group may also themselves, if they are using substances, be engaged in harm reduction and harm reduction offers an opportunity to engage them and talk about their role in terms of exposing other people to potentially harmful substance use patterns.

Now, in that light, I wanted to give an example that may not be the first thing that comes to mind when we talk about the intersection of harm reduction and prevention, but I think can be a helpful way of looking at it. As we've seen an increase in the last several years in many, if not most parts, of the country of injection drug use as a consequence of the broader dynamics of the rise of opioid and particularly heroin use in recent years, that there's been a fair amount of media attention and community attention and even policymaker attention to public injecting. Stories that you will see on the news or a viral video on Facebook of somebody injecting in a public space or being found with a syringe still in their arm. And when we look at the research, and these are some papers led by research in Canada, Dan [Warbin], his group, they find that most people who inject drugs report that early on when they transitioned from another form of drug use, perhaps they were smoking or snorting drugs, that the moment that they start injecting was facilitated by a more experienced person who injects drugs. Now, that doesn't necessarily mean that all people who inject drugs are facilitating that initiation, and it could be from an altruistic reason. "Listen, if you are going to do this, I want to make sure that you do it right. I don't want you to hurt yourself." Or it might be through different forms of social or peer pressure or other economic factors even. But, whenever you see somebody who is moving to that pattern of moving to the potentially more harmful form of drug use in the form of injection, there's usually a more experienced injector who is mediating that process.

And so, there's been some thinking that if we want fewer people to start injecting, then let's talk to these experienced injectors. There's an intervention that's been developed and piloted in a few places. I know some people in Denver, Colorado have been adapting it called Break the Cycle to say to people who are actively injecting drugs "Listen, you can break the cycle. Instead of bringing new people into injecting, let's talk to you about saying no when somebody asks you for help injecting, about not injecting in front of other people who are non-injectors to reduce the chance [in that concept of breaking the cycle], that more people will start injecting." But then that's at the individual level. We also know that exposure to public injecting, just the visibility of public injecting, can be a mediating factor in people's decisions about whether or not to inject, perhaps because they feel like that's normalizing it or it might seem less harmful than they might otherwise think. So, there's a broader discussion about ways to reduce public injecting that those, you know, Facebook videos and news stories that I was talking about earlier through community-level strategies.

So, most broadly, the ones that we have researched for effectiveness include housing people who are homeless, who might not have a private space to inject may be more likely to be injecting in public spaces; medication-assisted treatment, Sharon has talked about methadone/buprenorphine as options that we know overall result in a reduction in injecting and may mean that people are less likely to inject in public; and finally supervised injection facilities, which has been a topic in the news in some parts of the country and has been broader policy shifting in Canada in part in response to the overdose crisis that they are also seeing.

Now, I'm going to move from some of these examples of the overlaps and intersections between prevention and harm reduction to talk a little bit about the benefits of collaboration, and I think LaShonda started us off by talking about how the prevention field has a very strong legacy and commitment to collaboration. LaShonda, I know that you wanted to ask a question of the audience.

[LaShonda Williamson Jennings]: I do. So, "are you or your subrecipients involved with any of these activities? That's community opioid task forces, prevention coalitions, naloxone distribution, warm hand-offs, awareness campaigns or others?" Please describe that other in the chat box.

You know, it's been very interesting hearing all of the similarities we have, and I think that it's important, as we continue to have this conversation, we sometimes find ourselves feeling like if we were partnering with someone they must be doing exactly what we are doing and that we must be twins. And the reality is, what's been great about this conversation today, is simply it's okay to be cousins, that we all are the same family working together in love, using our humanity to really build this sort of ideal community, this healthy community in our minds.

So, let's go back to the chat and see that folks have their answers are being broadcast. It looks like there are twelve of us -- 54% of folks are saying that they are part of the community opioid task force, that they are part of prevention coalitions, naloxone distributions. We know that that is an incredibly popular strategy right now, but I am impressed with seeing that there are other strategies out there. In the chat box, it looks like the substance abuse initiative, so collaborations between local health systems and community agency leaders, Marietta [Hagan] asked about and Lisa Kendall, she's asking, "What's a warm hand-off?" Would you like to answer that question?

[Daniel Raymond]: Sure. Yeah. I think this has been an area of increasing interest in terms of making sure that people don't fall through the cracks, that when we make a referral, whether that's through SBIRT or if somebody ends up in the emergency department following an overdose, the question is how can we make sure that we don't just hand them a pamphlet and wish them good luck and put the burden on them to make a phone call and get connected to further support or treatment, but that there's a very direct connection?

A warm handoff physically could be a peer recovery coach or patient navigator or a case manager saying "I will walk with you to your appointment. I will stay with you and follow you and make sure that you don't fall through the cracks." So that's the concept and we are seeing this increasingly in terms of concerns about -- we've been doing a really good job with our naloxone programs whether it's community, family members, people who use drugs themselves or law enforcement, getting naloxone out and getting it deployed to save lives and the question that comes up is what's next? Right? What happens after somebody survives an overdose and can we use this model of a warm hand-off to counsel some people and, if they are ready, to seek treatment to move them in that direction through a very active process, rather than just giving them a list of phone numbers. So, I hope that's a helpful description.

[LaShonda Williamson Jennings]: Anybody else? Would anyone else like to add something to the chat? And, again, I'm going to remind you that you have an opportunity to ask questions, place them in the chat and Sharon or Daniel will certainly be willing and hopefully able to answer your question.

Let's go back to the slide deck, Daniel. Benefits to Collaboration.

[Daniel Raymond]: Thank you. Great. So, this an image that some of you may have seen before. It's a sea turtle and fish. It's a symbiotic relationship. So, they both have different roles. They both benefit from it, and it's a bit of a visual metaphor for collaboration. So, we want to talk a little bit about some core themes about ways that we can benefit by collaborating to address overdose together.

So, let's start with this concept of all hands-on deck, which many of you may have heard in the context of the current overdose crisis, that we cannot afford to all continue working in our silos, that there's too much work to do in the midst of this crisis that's claiming tens of thousands of years, so this all-hands-on-deck motif, which I feel like I've heard increasingly over the last couple of years. Really what that means to me is that overdoses become a focal point for galvanizing community, media, policymaker attention, and community mobilization. Communities are responding in many different ways to this crisis. Now, to harness that energy, it really requires concerted action from all parts of the substance use continuum of care.

So, we have spent some time talking about community strategies to expand naloxone access. We will hear some concrete examples of that from Sharon later. Really, those opportunities for engagement of multiple sectors and stakeholders, and we saw from the poll that many of you are involved in opioid task forces in different community coalitions, and then when I was talking about warm hand-off, that need for follow-up support for overdose survivors and their families where there's often a fact of repeat exposure and trauma among both community members and professional responders. So, all of these and many more are real opportunities where none of us can solve these problems on our own, but if we work

together, this all hands-on deck mentality, then we have these opportunities. I think we saw some of this reflected. I'm sure many of you saw the news about the White House Opioid Commission that New Jersey governor, Chris Christie, spearheaded just recently released recommendations and they talked about getting thousands of suggestions via email, through meetings, from all different sectors of the substance use continuum. We also saw this last year when the former surgeon general released his report on Facing Addiction in America. Lots of discussion of prevention, a very good section on harm reduction. That concept of bringing people together and recognizing that this not a job for just one person. This is a real requirement for all of us to work together.

And then in terms of collaboration, one thing that I found collaboration makes possible is translating across sectors. So, we all have our different jargon. We all have our different acronyms. We all have our different frames of reference and so even making sure that we have mutual working definitions so that we can be in a conversation with each other that's mutually intelligible. Collaboration on opioid overdose prevention gives prevention and harm reduction fields and workers opportunities to develop that common vocabulary and really get a better understanding of each other's activities, priorities, and knowledge.

Earlier this year, and in previous years, I've been at the National Prescription Drug and Heroin Abuse Summit that's held in Atlanta. Some of you may have been attending. And it's a really interesting moment for me. We have our own National Harm Reduction Conference every two years where we bring together the harm reduction community, but in something like the National Rx Summit, it brings together people from all kinds of sectors, bumping up against each other -- prevention, treatment, recovery, harm reduction, law enforcement -- and I feel like that's a really good opportunity to figure out what's on everybody else's mind and what happens when we can all get into the same room together and really talk.

Now, another benefit of collaboration, which I'm sure is not new to you, is the opportunity to share knowledge for action. So, prevention and harm reduction each bring different insights to the table. Whether we are talking about overdose specifically or even broader drug trends and strategies. We also touch and learn from different parts of the community. That may be families, that may be school systems, healthcare, criminal justice, the business communities, and so forth. So, when we collaborate on something like overdose and we are all at the same table, it gives us space to share actionable information and gain a broader vantage point.

And I think about one group that has been doing this. I'm based in New York City, so here in Staten Island we have a collaboration called Tackling Youth Substance Abuse. It's a bunch of people that came together using a community impact framework to say, "listen, we have a real problem in Staten Island. We are seeing overdose rates go up…" and when they formed, it was primarily prescription opioid overdose rates, "and we are seeing a lot of challenges in our schools. We really need to do something." So, Tackling Youth Substance Abuse came together. It's prevention-focused, but it also includes harm reduction strategies

for opioids and it's also been supportive of naloxone training, education, and distribution. The knowledge that gets shared through this collective impact framework that they are using feeds into everybody's work no matter what sector that you are in and so people aren't just stronger together, they are smarter together.

Another benefit of collaboration in my mind is a bigger pool. That I think all of us feel like we could use more stakeholders, more volunteers, more people paying attention to the work, more people showing up for our events, more people supportive of our efforts. In harm reduction and prevention, we each have distinct advocates, supporters, constituents, stakeholders, and networks. There's certainly some overlap, but we also each are reaching these different segments. So, collaboration gives us the framework to draw more into the work that each sector is doing and I think of this in terms of these county task forces or in some cases governor's commissions. Last year, in New York, I served on Governor Cuomo's Heroin and Opioid Task Force and it was people from recovery, people from drug treatment, people from the prevention side, law enforcement and we went out and jointly did listening sessions across the state and, again, the composition of the listening sessions mirrored people from diverse sectors and these task forces could have a galvanizing effect in exposing new people to each other's work.

And then joint action. Because that's really what it's all about. The goals that we share, the impact that we want to have that becomes more likely to happen when we are all joining hands and working together. And so, as Sharon said in the conclusion to our first section, effective overdose prevention really requires coordinated messaging and strategies that we want the same thing so let's work in the same direction. When we work together, prevention and harm reduction can accomplish much more than either sector would be able to do on its own. And I think about a lot of examples from community or county task forces. For example, in Pennsylvania, the Delaware County Heroin Task Force has worked collaboratively on a bunch of different initiatives. They've equipped all of the law enforcement officers in the county with naloxone and they are seeing successful overdose reversals. They've collaborated on prescription drug take back days. They work with a local group on school-based education and they come together for community awareness events.

And you can imagine other opportunities. If you are organizing your own prescription drug take back day and the DEA has its own national events every year. Or community forums. Can you integrate a naloxone training? Can you have somebody providing education on Good Samaritan laws which, I don't know that we've spoken much about, but if you are not familiar with them, about two-thirds of states have them and they address concerns that if I call for help because my friend is overdosing, I might be deterred from making that call to 911 because I'm afraid I'm going to get arrested, but these laws, so you are acting as a Good Samaritan. You are trying to get help for an overdose. You won't be arrested or charged. The technicalities vary in every community but that could be a focus of education accompanying these community forums or prescription drug take back events.

And ultimately, it is really about having that greater impact. Overdose prevention provides an opportunity for harm reduction and prevention fields to expand our reach, increase our impact, and develop a united front that multiplies our influence among community members, policymakers, media, and key institutions. We are stronger and achieve more when we work together. And we have different opportunities coming up around that. The end of this month for example, August 31st, has been recognized as Overdose Awareness Day. A great opportunity for all sectors of substance use from prevention to harm reduction to treatment to recovery to really come together, honor the lives lost, and commit to collective action moving forward. That's August 31st and then we move right into National Recovery Month. So, rather than us seeing these as discrete events for different sectors, these are events for us all to come together and bring in other members of the community to share a broader vision and make sure that we are aligned in our efforts to address the overdose crisis.

I'm going to turn it back to LaShonda now.

[LaShonda Williamson Jennings]: Great. So, we have another poll question for you all. Which of these partners, partner groups, are you or your subrecipients currently engaging in opioid misuse and overdose prevention efforts? Pharmacists, prescribers, law enforcement, corrections, schools, professional first responders, or others. And if there is an "other" that you have, please place it into the chat box right below the question. So, again, which of these partner groups are you or your subrecipients currently engaging in opioid misuse and overdose prevention efforts?

I know that here in Oklahoma I think that there has been some engagement with pharmacists. There has certainly been engagement with schools and law enforcement. I mean, this is an issue that becomes not just one group's issue to address, but truly these issues are -- it's a community. It takes a village to address this issue.

I'm seeing down below, I see social service agencies, faith, community, local government leaders, etc. The media has been listed. Bystanders have also been listed. Is there anybody on here, you Daniel or Sharon, is there anyone on here that you've utilized or worked with and it's not listed above?

[Daniel Raymond]: Yeah. I think Sharon would say that we've increasingly done work with drug treatment. One of my staff did some trainings today with housing providers and homelessness services. I have done a little bit of work with domestic violence agencies and I think we could add reproductive health to that list.

[Sharon Stancliff]: And we've also worked with all of these that are listed, which I think is showing another crossover between harm reduction and prevention. We have the same partners.

[LaShonda Williamson Jennings]: Absolutely. I'm seeing folks write in the chat box, advocates. I'm seeing housing providers, bartenders, social service agencies, foster care.

[Sharon Stancliff]: I've done overdose prevention trainings at barbershops.

[LaShonda Williamson Jennings]: Barbershops? Okay. So, treatment providers, probation and parole officers, social services agencies, state agencies, insurers. I'm seeing advocates again. I mean, recovery homes. We certainly should put barbershops on there. You know, tell us why you went to a barbershop?

[Sharon Stancliff]: Well, in some parts of New York City they are really a place where people not only get their hair cut but they hang out. And this was particularly up in Harlem, so I collaborated with an agency that was in the neighborhood to do an overdose prevention training, having stopped at the barbershop before. They said, yeah, people would be really interested. So, it was partly a form of perhaps entertainment, but there were definitely people that wanted their naloxone kits there.

[LaShonda Williamson Jennings]: Excellent. Thank you for sharing. We know that in some neighborhoods that barbershops are certainly, you know, one of the cornerstones of the community where people come together and talk about what's happening in the community, so interesting place.

[Sharon Stancliff]: And I'd like to take this chance actually to mention the event that we will be doing later this week called Shaping Sanctuary where the harm reduction coalition is collaboration with Judson Memorial Church to work together with faith-based communities and we will have people from a variety faiths speaking in honor of International Overdose Prevention Day.

[LaShonda Williamson Jennings]: Thank you for sharing that. So, we no longer need our polls. Thank you all for responding. I certainly appreciate it and we are going to go back to our slide deck.

[Daniel Raymond]: Great. Thank you, LaShonda. Sharon, I will turn it over to you.

[Sharon Stancliff]: Okay. So, we were asked to talk about some examples of partnerships between prevention and harm reduction and I chose a couple of the projects that have been the most exciting to work on because I think they really do fill the example of that and I love that poll because it turns out that at least for some of you these will be relatively familiar partners.

I hope that you all know, although it doesn't seem to get around, that the Centers for Medicare and Medicaid Services in their opioid misuse strategy has singled out many things. It's a worthwhile plan to look at, but I specifically chose increasing access to

naloxone by requiring that the anecdote appear on all Medicare Part D plan formularies and then increasing the use and distribution of naloxone for Medicaid beneficiaries, which is pretty close to requiring them to cover it and specifically they require that it be on all of the market place plan formularies. So, in New York state almost all of Medicaid is covered by managed care programs and they all need to include naloxone. So, you know, thinking back to our maps. This is a big change in access and I hope this might be helpful for you all thinking about how to get more access.

So, at this point, and I don't know why these two states haven't jumped in, but at this point we only have two states that have not by some mechanism or another allowed naloxone to essentially appear to be over the counter in pharmacies. In some states, pharmacies actually have prescribing authority. In other states, they have collaborations with various entities. Here in New York state, I'm one of several doctors that provides a standing order to pharmacies, so if you go into a Rite-Aid in Schenectady and ask for naloxone, you will find my name on it. If you do it in Rite-Aid in New York City you will find our Commissioner of Health's name on it.

So, naloxone is finally in pharmacies. Doctors and nurse practitioners and physician assistants in most, if not all, states, all three folks can prescribe it, so we have multiple ways to get it out there. As I say, you can go to your physician and get a prescription for it when you are getting your Tylenol-3 because you had a tooth pulled. There's no reason why not to get some naloxone with it. You can get it from an emergency medicine department if you go in with an overdose. Or a whole variety of other prescribers and, as I say, in many, many -- in almost all states, you can go to at least some pharmacies and request naloxone and your insurance may cover it, but you should be able to purchase it.

This uptake has been really slow though. There's been a few journal articles about various mechanisms to try to get people to use this way of getting naloxone. Rhode Island has done some major advertising campaigns. New Mexico, I think, has had some success. If any of you have had success in your state, please chat and type that into the chat box. But it's been slow in New York. We've had in the pharmacies for a couple of years now and slowly it's beginning to pick up, but the copayment is a barrier. People usually need to pay some copay at a pharmacy. We do have multiple programs in New York state where people can get free naloxone, but that's getting to be a six-million-dollar budget as people do have insurance that could cover it.

Now, in New York, and I don't know how it works in other states, very often pharmacies will quietly wave Medicaid copays which tend to be quite low, but that can't be advertised because it doesn't quite go with their contracts and people don't always want to ask for a waiver of copay.

So, there are several barriers to getting out through pharmacy, but this is one that many states could do what New York state has chosen to do. Effective just last week, the State

Department of Health decided to cover copays of naloxone in pharmacies up to $40. So, this is quite a collaboration. It includes the pharmacies that are collaborating, state and county health departments in terms of getting the orders out to the pharmacies, medical prescribers. Community-based organizations will need to get the word out there. So, it's a lot of collaborators working on overdose prevention from a lot of different points of view.

I have to say, by the way, one of the things that I've tried over the years to do is to bring pharmacies in as public health collaborators. They are medical professionals that can do a lot and I think the more we can include them in some of these crises the better.

So, the New York State Department of Health uses its overdose funding to cover the insurance cost of copays. They think that the average cost of a copay is around $10. The cost of a -- I actually underestimated here, but the cost of intranasal naloxone kit with two doses is at least $70 more depending on the formulation. So, if it can go out to a pharmacy on insurance it makes more sense. And basically, every state has an AIDS Drug Assistance Program so many, many pharmacies already have a mechanism by which they can bill the state. So just to be clear, it's not HIV money that's covering the naloxone, but the system that allows pharmacies to bill the state for the AIDS Drug Assistance Program can also be used to bill the state for other purposes. So, it's very user friendly. Nobody needs to sign up for it. They just simply can say, "Hi, pharmacist. I would like to get my naloxone. Here is my insurance card." And the pharmacist will know what to do to bill part to the insurance and part to the state.

So, it's just begun as of Friday. I haven't gotten an update. There were 21 uses of it. It will take a lot of collaboration. We think that we can get the syringe exchanges where people are getting naloxone free to say, "hey, if you use this on Saturday afternoon and you can't get back to the exchange until next Wednesday, you can go to a pharmacy." I'll be showing you in a moment about our prison project where people can get a kit on their way out the door. But they can go to a pharmacy if they need it. Pharmacies are available in rural areas. We also allow for purchase of syringes, 10 or fewer syringes, at pharmacies, which is not detracted from the use of the syringe exchanges, but has expanded access to clean needles and we are looking at this collaboration in essentially the same way.

So, now I'm going to turn to another really exciting collaboration that we have which is, I mentioned, the Harm Reduction Coalition collaborates with the New York State Department of Corrections and Community Supervision (Community Supervision, meaning parole essentially), and the Department of Health in, I think, what is an extraordinary collaboration. All soon to be released inmates, regardless of their drug involvement, are being trained on opioid overdose prevention including the use of naloxone, but also an understanding the risk factors and they are being offered naloxone kits free of charge on their way out the door.

We do know that the risk of death following incarceration, especially in the first week to two after incarceration, is extremely high and that the majority of those deaths are due to overdoses, primarily opioids, but also other drugs. So, it's similar to drug treatment, a period of abstinence. People come out and they are at risk of death. So, they come out. They may not realize the supply has changed now that we've got Fentanyl in it. They may believe that they can take the same dose that they took before they were ever incarcerated. They may also be partying a bit much having been released from prison. So, we lose a lot of people. But we also know that effective overdose prevention can be taught in less than ten minutes and, in fact, you might want to Google it. We will send out the research -- the link later, but the video that's been created for the prison population can be found if you Google Staying Alive on the Outside in New York and it really is a paragon of collaboration I suppose. It's got the commissioner of the Department of Corrections in it, a person on parole that's used naloxone. It's got inmates in it. It's got correctional officers in it. Somehow, they've all come together on this project.

So, in New York, we have 54 prisons. I'm happy to say under the current state administration the number of prisons and people incarcerated has decreased. Several of the facilities are focused on drug-involved inmates and parolees. There's one prison that is primarily for people that have had drug-related violations while on parole. They are sent back for what's called a 90-day boot camp shock treatment. About 22,000 people are released each year. That's a lot of kids. And as an aside, I also want to point out that the Department of Corrections also has publicly recognized that drugs do get into prisons. Therefore, their nurses and soon I believe some of their correctional officers have a standing order to use naloxone if someone is unconscious and it's at all possible it was an opioid overdose. They use it quite easily. I know they've used it often. I can't tell you how many overdoses they have reversed, but I know it's been several since that new regulation came into effect.

On the training components, just to review very quickly. The video and the trainers go over the risk factors for overdose: use that for abstinence, mixing drugs, changes in drug supply, using alone, making sure that people can recognize the signs of a potential overdose. What is this naloxone and how do you administer it? The prisons are distributing intranasal formulations (needles and prisons don't go together very well). So, how to respond to the overdose? Basically, sternum rub, use naloxone, call 911. We wish they would come back and report it. We hope that they will get a refill and making sure that they know it's legal and that Parole is collaborating with us. Parole -- they always have to report police involvement to Parole, but the parole officers understand that there are many circumstances. One that did report it, basically got off a bus in the neighborhood and found people standing around somebody who had overdosed, so his police involvement was fine. He's on video getting congratulated. If someone has used in the shooting gallery at 4 in the morning, it will be taken into account, but that's a little bit different, of course.

So, what kind of messaging do we give to the inmates? I think that this is really valuable in several different ways. We are not only telling inmates that "some of you may lapse or have a relapse. We want you to live to try to make it again" and that's a message we give out in drug treatment as well. "You may have a relapse when you leave. In drug treatment" they say "we want you to live so you can come back." Prison doesn't usually say we want you to live so you can come back. They want them to stay out.

But the other thing, whether we are talking drug treatment or people leaving prisons, they are also being told, you know, you will leave and you will try to stay away from drug-related settings, but in some places the drugs are so widespread that that's really hard. Coming back to a housing project in New York City. Going back to a very small town where there's rampant use of opioids. So, we are telling them "we think that you are a good enough citizen now that you could save a life using this kit." So, I think that's a really powerful message to people that, you know, I hear these guys call themselves ex-cons and all kinds of things that essentially are derogatory towards themselves, so I think it's an exciting program. There will be an evaluation by the Vera Institute of Justice coming out before the end of the year on some of the qualitative levels of it.

Here's a picture from our very first training at Queensboro Prison. You can see in the back Superintendent Breslin who really was the champion making this whole program work out. So, we began it in February of 2015 and at this point there's over 5000 formally incarcerated people in New York carrying naloxone and honestly the number may be higher. Until recently, Harm Reduction Coalition was essentially involved in every training. Docs has now internalized it and they are training in many more than the ten prisons that we worked in. So, they've internalized the process. They want it to be their program.

So, a few of the things that were successes was really finding inside advocates who can provide navigation and this happened in this little process of one of the agencies that has a needle exchange and does naloxone distribution, also had people going into the prison to do HIV prevention and linkage work for the prison. So, this one agency that was doing several different things, was able to show the naloxone training first to the staff and then to this wonderful superintendent that's like, "we can save lives this way." So, that in and of itself is a fascinating collaboration.

To be more specific to it, we did find it was really helpful to train the staff first and what was perhaps even shocking to us is we learned pretty quickly that many of the correctional officers are losing family members to overdoses. It's incredibly common in their communities and during the time we've been doing this project, they have actually lost at least two correctional officers themselves to overdose death, so this really crossed a bridge between correctional officers and prisoners who, of course, there's a big gap between then and in fact some of the correctional officers were like, "we would like to train the prisoners," which is something that does not happen in correctional facilities at all anywhere, so I'm told.

And, so having those staff volunteers do the training was an example to their peers across the 54 prisons. That they were like, well, I'm doing this and I believe in it. So, it wasn't just that Harm Reduction Coalition went in and said you are going to do it because we say how you do it, it was because we help them teach their peers, which I think was key.

So, it's an exciting program and I'm hearing about other states that are beginning to institute this. I'm hoping to hear more about that in the next little while. I do recommend checking out the video. It's a really great video.

So, as Daniel and I both said, we have additional resources available on our website, including a link to that video as well. A lot of information on naloxone. Some on the supervised injection facilities, we mentioned, of course, a lot on syringe access and links to our conference which will be in New Orleans in 2018.

So, I think that we are now opening up for, as one of my colleagues puts it, questions, comments, or curse words.

[LaShonda Williamson Jennings]: Well, we hope no curse words. But, we certainly would love to have questions or comments that you all have been formulating since the beginning of this presentation today. I feel like, Sharon and Daniel, you all have done such a fantastic job today sharing with us, you know, what is harm reduction and then how does it intersect with the work that we are doing? So, it's great to hear that we have common goals. That we serve some of the same folks in the community and then sharing those different ways of working together.

So, while we are waiting for a question to appear on the screen, I have a question. The last part of the presentation was about collaboration. So, where do we find harm reduction practitioners? If there's no brick and mortar or sign on the door that says, you know, Harm Reduction Coalition like in your community, where do we, in our communities, find harm reduction practitioners to partner with?

[Sharon Stancliff]: Well, I think in order to find some of the syringe exchanges around the country which are often niduses for other harm reduction services, you can look on our website and check state by state. You can also email us and we know some of the other services that are around. I mean, some places label themselves as harm reduction. Other places practice a lot of harm reduction without labeling them as such and since we are a national organization we can sometimes help you in local places find what's going on. And our health department, too. Because we have a lot of connections across New York state and New York City Departments of Health have a lot of connections across the country with other health departments that have done some of this work.

Daniel, can you add to that?

[Daniel Raymond]: Sure. I think for myself when I'm looking around for local harm reduction providers, certainly start with our website and we are happy to field questions and make connections. There's also, for syringe exchange, I think there's perhaps even more up to date than our website, the North American Syringe Exchange Network maintains a state-by-state listing with, I think, some contact information and websites and so I've been impressed by how thorough their state directory is. There is also, and Sharon you might be able to help me with this, I know that some people from Massachusetts, I believe, put out an overdose program locator. It's a little widget that is meant to be a directory that you can enter your zip code into for any surrounding community-based overdose prevention and naloxone distribution programs.

Sharon, do you know more about that?

[Sharon Stancliff]: We actually have a link to it on our overdose page. But we didn't create it, but we do link to it right there and I should be able to say who created it.

[Daniel Raymond]: Some colleagues that we are very grateful to even if we can't remember their names at the moment.

[Sharon Stancliff]: Right, right. And I think it's also found on a website called Prescribed to Prevent which has a lot of the information one would need to give to pharmacies and to prescribers on getting naloxone out.

[LaShonda Williamson Jennings]: Well, thank you all.

[Sharon Stancliff]: I'm wondering if anyone has any thoughts of something they might bring to their agency tomorrow to think about doing differently or?

[LaShonda Williamson Jennings]: I see a question: "Any specific advice, suggestions for communities not yet in the crisis mode, but more proactive?"

[Sharon Stancliff]: I wonder where those communities are. It seems like such crisis mode across the country for sure. But certainly, there are sort of different ways that we need to go about this. There is the idea of judicious opioid and benzodiazepine prescribing that needs to come out using perhaps the CDC guidelines among medical providers. Unfortunately for that, sometimes that sort of signals a shift over to illicit opioids and that is not a good outcome from that, so we need to work on both sides. I would look around at what you've got for treatment in the community. Make sure that people can get access to our best evidence-based treatments which is buprenorphine or methadone so that as people get into trouble, they can get out of trouble more quickly which in some ways adds on to what Daniel was saying about preventing people from moving on to injecting. So, having the treatment right there. I feel like the country kind of made a mistake in reducing the access to opioids that were prescribed without significantly increasing access to treatment.

There are some that find that education, not all studies have found this, but it also appears that education about naloxone helps people understand the seriousness of opioids. In one study where they prescribed it to people receiving opioid prescriptions, they compared those that did not get a prescription for naloxone and they found a very significant -- a 63% reduction in emergency medicine visits. And they weren't able to hear the people were using naloxone and part of the effect may have been simply these are dangerous medicines or these are dangerous drugs. We want to make sure that you have the anecdote to it. It may not only save only lives through the actual use of the naloxone, but through the conversation starters.

Maybe you can add to that, Daniel?

[Daniel Raymond]: Yeah. I think it's a great question and I can only imagine that there is a number of communities that wish they'd asked themselves that a lot earlier before they got into the crisis mode. I think there's a couple of pieces to that for me. One is that if you are not yet in a crisis and you do have an opportunity to learn from the best, learn from states that have gone further down that road. I've, in various ways, been particularly impressed by some of the responses that we've seen from states in New England in particular. I'm thinking about Rhode Island, Massachusetts, and Vermont in different ways.

Rhode Island's governor commissioned an opioid task force report that was provided by some of our colleagues and it was very thoughtful in terms of its recommendations and I think in terms looking at how to get ahead of the curve that some of the work that our predecessors have done can be relevant in thinking about what kind of systems and structures need to go in place. I think it's also maybe almost framing it as a question. If you are dealing with stakeholders who say, "oh, that's not a problem here" or "that's not going to happen to us," thinking about what kinds of data that you can line up to show that it might not be a problem yet, but we are not too far away from it potentially becoming one, so let's take almost an emergency preparedness or let's get our metaphorical go-bag ready, so that in case we do see signals that it is hitting here, then we are prepared and we don't have to play catch-up.

I was struck by this that many of you may have seen the headlines of two to two and a half years ago that Indiana in the wake of struggling with some overdose and prescription opioid issues experienced a significant, really unprecedented HIV outbreak in a non-urban area in southeastern Indiana among people who were injecting prescription opioids, specifically a painkiller called Opana and that was the case study of a community that was not prepared, did not have this on their radar screen at all. One of the things that SAMHSA's federal partner, the Centers for Disease Control, went and did is say "can we predict what underlying factors contributed to this so that we can identify other counties across the country at risk of a similar outbreak?" So, they looked at some, they crunched some numbers, some data and found some indicators and identified over 200 counties across the country that might have similar conditions making them ripe for an HIV outbreak. And I think

in broader terms around opioid overdose it might be possible to think along similar terms. What other communities might we look like and resemble that have already seen an outbreak and what can we do to identify those preexisting conditions and take the steps to prepare in case we see this in our community?

[LaShonda Williamson Jennings]: Excellent. Excellent. Thank you all for answering that question. Are there any other questions? I'm not seeing any more at the moment.

Let's move on to briefly talking about the Prevention Collaboration in Action toolkit. It's a toolkit that has been developed by the CAPT and the toolkit features tools and worksheets designed to strengthen your collaboration in your community. You will also find stories of successful collaborations that have happened with SAMHSA grantees. You will also notice there is a circle around focus on opioids. Please go there and look at this focus on opioids. The tools are where you can find our great worksheets and toolkits. It's certainly an excellent website to peruse and so I think that, you know, either as an end of the day activity or to start your morning off tomorrow it is wise to check out this Collaboration in Action toolkit, and I'm going to move forward to also go to harmreduction.org.

So, we are at the end of our presentation today. Thank you so much, Sharon. Thank you so much, Daniel, for sharing your information. We are so appreciative that you partnered with the CAPT to talk about how prevention practitioners, as well as harm reduction practitioners can collaborate and collaborate more successfully so, you know, it's so much easier to work in conjunction with someone when you know a bit more about them. So, you know, I feel like I am armed with some more tools today and I know a bit more about harm reduction and I am able to start to formulate what will be my next steps. What will I do with the information that I've received today?

So, if you have any questions today, please contact Amanda Doherty and before you leave we definitely appreciate it if you fill out our evaluation, so take a moment to let us know what did you think about today's webinar. Simply click the link on your screen, just clicking that button on your screen, or there will be a link in the chat box.

Again, thank you so much, Daniel and Sharon for sharing your information today and everyone please fill out our evaluation.

[Sharon Stancliff]: Well, thank you. I think it has been a great collaboration between us and CAPT.

[Daniel Raymond]: Yes, I thank you. I appreciate the opportunity and I hope that this leads to more collaboration in the future.

[LaShonda Williamson Jennings]: Absolutely. Everybody, after filling out your evaluation, please take care.